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ABSTRACT

This document provides general background information and interprets state and federal rules as they apply to occupational and physical therapy in educational settings. Iowa state definitions of occupational and physical therapy, the roles of the physical therapist and occupational therapist, and the role of paraprofessionals are described. A chapter on service delivery covers the multidisciplinary team, identification of pupils warranting evaluation, development of the individualized education program, service models, and exit criteria. The last chapter focuses on administrative considerations, such as scheduling and caseloads, supervision and evaluation, and liability. Includes eight references. (PB)

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Iowa Guidelines
for Educationally Related Physical & Occupational **Therapy Services**

EC 230556

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INTRODUCTION

In 1975, congress enacted Public Law 94-142, The Education of All Handicapped Children Act which, in conjunction with the Iowa Special Education law, provided the foundation for education of all handicapped children, provision of services, rights to due process, and equal protection. This legislation mandated a free and appropriate public education, including support services such as physical and occupational therapy, to assist the handicapped child in benefiting from special education.

Although physical therapists and occupational therapists have provided services in public and private schools throughout the history of the profession, Public Laws 94-142 and 99-457 have broadened the role of these therapists and increased the demand for employment of therapists and assistants throughout the state and the nation.

The purpose of this document is to provide general background information and to help interpret state and federal rules as they apply to occupational and physical therapy in educational settings. Therapists and administrators across the state of Iowa have had input into this document throughout the development process. This document is intended to serve as a guideline so that each area education agency (AEA) employing therapists can establish or update specific agency guidelines for providing these support services to handicapped students in special education.

Inherent in this document are the following assumptions:

1. Pupils should be placed in the least restrictive educational environment possible.

2. The educational relevance of an activity is defined by the educational curriculum of the pupil.

3. The educational environment is the location where a pupil's curriculum is being implemented. For example, the educational environment of an infant may be the home; for a school-aged pupil it would be the school and surrounding grounds, and for a pupil with prevocational or vocational goals, it may include the community.

4. Motor functioning is an area which may be assessed by various different disciplines (e.g., psychologists and physical education teachers). Therapists assess motor functioning from the unique perspective of physical therapy or occupational therapy.

5. Even though services may overlap, physical therapy and occupational therapy are separate disciplines with separate entry-level educational experiences and separate licensure laws.

6. Physical therapy and occupational therapy should both be available to special education pupils as needed. Equal availability of therapies is assumed.

TABLE OF CONTENTS

INTRODUCTION i

I. PERSONNEL

Definition: Physical Therapy 1
Iowa Law 1
Department of Education Rules 1

Definition: Occupational Therapy 1
Iowa Law 1
Department of Education Rules 2
Comment 2

Role of the Physical Therapist and the Occupational Therapist in the Educational Setting 2

Definition/Role: Paraprofessionals 3
Physical Therapy Assistant-Aide 3
Occupational Therapy Assistant 4
Iowa Law 4
Comment 4

Other Personnel 4

II. SERVICE DELIVERY

Introduction 5
Multidisciplinary Team 5

Identification 5
Screening 5
Pre-Evaluation Activity 6
Referral 6
Assessment 7
Assessment Areas 8
Staffing 10
Entrance Criteria 11

Implementation 11
IEP Development 11

Models of Service 13
Direct Service Model 13
Integrated Service Model 13
Consultation Service Model 14

Therapy Intervention 14

Exit Criteria 14

III. ADMINISTRATIVE CONSIDERATIONS 15
Employment of Occupational and Physical Therapist 15
Authorization for School Therapists 15
Orientation of New Staff 17
Scheduling and Caseloads 18
Equipment and Space 18
Documentation 19
Supervision and Evaluation 20
Continuing Education 20
Coordination and Delegated Tasks 21
Liability 21

REFERENCES 22

APPENDIX A: OT/PT Criteria 23

APPENDIX B: Considerations for Service Model Selection 25

I. PERSONNEL

Definition: Physical Therapy

Iowa Law

The Iowa Physical Therapy Practice Act, Chapter 148A of the 1984 Iowa Code defines "Physical Therapy" as "that branch of science that deals with the evaluation and treatment of human capabilities and impairments. Physical therapy uses the effective properties of physical agents including, but not limited to, mechanical devices, heat, cold, air, light, water, electricity, and sound, therapeutic exercise, and rehabilitative procedures to prevent, correct, minimize, or alleviate a physical impairment. Physical therapy includes the interpretation of performances, tests, and measurements, the establishment and modification of physical therapy programs, treatment planning, consultative services, instructions to the patients, and the administration, and supervision attendant to physical therapy facilities. Physical therapy evaluation and treatment may be rendered by a physical therapist with or without a referral from a physician, podiatrist, or dentist, or chiropractor, except that a hospital may require that physical therapy evaluation and treatment provided in the hospital shall be done only upon prior review by and authorization of a member of the hospital's medical staff."

Department of Education Rules

According to the Rules of Special Education, Department of Education, 12.25(3)h, the school physical therapist applies principles, methods and procedures for analysis of motor functioning to determine developmental and adaptive sensorimotor and gross motor (positioning, mobility) competencies in order to plan, counsel, coordinate, and provide intervention strategies and services for pupils with physical impairments.

This definition of "School Physical Therapist" does not limit physical therapy services to pupils with primarily physical impairments but may also include pupils with other handicapping conditions which may interfere with motor performance which affects their educational performance.

Definition: Occupational Therapy

Iowa Law

The Iowa Occupational Therapy Practice Act, Chapter 14B of the 1981 Iowa Code defines occupational therapy as: the therapeutic application of specific tasks used for the purpose of evaluation and treatment of problems interfering with the functional performance in persons impaired by physical illness or injury, emotional disorder, congenital or developmental disability or the aging process in order to achieve optimum function, for the maintenance of health and prevention of disability.

The professional defined in this Act includes: the occupational therapist defined as a person licensed under this chapter to practice occupational therapy.

Department of Education Rules

The Rules of Special Education, Department of Education, 12.25(3)g, defines the School Occupational Therapist as one who applies principles, methods and procedures for analysis of motor functioning to determine developmental and adaptive fine motor, sensorimotor, positioning and self-help (feeding, dressing, vocational competencies) in order to plan, counsel, coordinate, and provide intervention strategies and services for pupils with physical impairments.

This definition of "School Occupational Therapist" does not limit occupational therapy services to pupils with primarily physical impairments but includes pupils with other handicapping conditions which may interfere with motor performance and therefore their educational performance.

Comment

In the educational setting, physical therapy and occupational therapy are support services. The physical/occupational therapist is a member of a multidisciplinary team whose purpose is to determine an appropriate educational program for the handicapped pupil. The therapist utilizes his/her expertise to develop and maintain the motor potential of a handicapped pupil for functional independence in the least restrictive educational setting. The school physical/occupational therapist is not responsible for the total rehabilitative/habilitative process of each pupil. Other aspects of a pupil's adaptive functioning outside of the educational setting may be the responsibility of other professionals (e.g. hospital and/or private therapist).

Role of the Physical Therapist and the Occupational Therapist in the Educational Setting

Physical therapists and occupational therapists are traditionally trained and employed in the medical setting to evaluate, treat, restore function, and prevent disability primarily with disabled persons. The orientation toward evaluation and treatment is closely related to the medical needs of these clients.

Employment in the field of education with children requires further special training for the physical or occupational therapist to effectively provide educationally related services. Therapists need background in general human and behavioral development, neuromotor development and treatment techniques, the design and use of adaptive equipment, parent-teacher-team training techniques, rules and regulations of special education, writing IEPs, etc. Therapists in education are members of a multidisciplinary team. The pupil's disability must be identified, but more importantly, the pupil's capabilities in relation to current educational needs are the focus for programming to promote functional independence within the present environment. A pupil may have an educational diagnosis (mental disability, physical disability, learning disability, behavioral disability, etc.) and may have difficulty meeting

demands of the school day but not have acute/chronic medical problems. In this case, the multidisciplinary team may identify the need for physical and/or occupational therapy to improve motor development or motor performance as it relates to the educational performance of the pupil.

Some handicapped pupils may have a medical disability or motor impairment, identified by a medical facility, which does not interfere with educational performance. The multidisciplinary team may determine that the pupil does not require physical or occupational therapy through the educational program. The school physical or occupational therapist does not have an identified role in this situation. The pupil's family may pursue therapy services outside of the educational program. The team may provide information regarding therapy resources, at the family's request.

Other handicapped pupils may have a medical diagnosis which significantly affects their school performance. In this case, the pupil may require physical and/or occupational therapy services in both medical and educational settings. The school therapist's role in this situation would be to provide service to the pupil as well as to communicate with medical personnel involved with the pupil.

In education, the needs and demands placed on the handicapped pupil may change from year to year. Therefore, the role of the physical or occupational therapist and the amount and type of service may also change. In general, the school physical or occupational therapist's purpose is to enhance pupil performance and assist the educational process, not to meet the total medical needs of the pupil.

Definition/Role: Paraprofessionals

Physical Therapy Assistant-Aide

The Physical Therapy Assistant (PTA) is a graduate of a two year accredited education program. A PTA is trained to work under the direction of, and as an assistant to, the physical therapist administering physical therapy programs. The State of Iowa Board of Physical and Occupational Therapy Examiners does not recognize physical therapy assistants as licensed professionals. They are, therefore, considered as physical therapy aides working under the direction of a physical therapist.

According to the Rules of the Board of Physical and Occupational Therapy Examiners, "Physical Therapy Aide is an unlicensed person who receives on-the-job training and provides physical therapy services to the handicapped pupil. The following conditions are necessary in accordance with Rules of Iowa Board of Physical and Occupational Therapy Examiners effective October 31, 1984:

"a. Physical therapist shall not delegate to an unlicensed person under the supervision of the physical therapist a service which exceeds the expertise of the unlicensed person being supervised.

b. Care rendered by supportive (to the therapist) personnel shall not be referred to as physical therapy unless,

1. The physical therapist has physically participated in the patient's physical therapy evaluation or treatment or both each treatment day.

2. The physical therapist assumes responsibility for all delegated treatments".

If the above conditions are not met, then services provided by a physical therapy assistant or aide cannot be called physical therapy.

Occupational Therapy Assistant

Iowa Law

"Occupational Therapy Assistant" (COTA) is defined as a person licensed under Chapter 148B of 1981 Occupational Therapy Practice Act, to assist in the practice of occupational therapy.

In an educational setting, COTAs are directly supervised by occupational therapists and provide occupational therapy services to handicapped pupils requiring occupational therapy. In some situations, a COTA may be supervised by a physical therapist, however, the services delivered by a COTA under these circumstances may not be considered physical or occupational therapy.

Within the school setting, COTAs are trained to provide occupational therapy services but are not to be considered as or hired as occupational therapists (OTR). The actual duties of the COTA shall be determined by the supervising therapist based on the needs of the pupil population requiring the service and shall be performed in accordance with the Iowa Occupational Therapy Practice Act.

Supervision is defined in the Occupational Therapy Rules and Regulations as a minimum of four hours a month of on-site and insight supervision for each occupational therapy assistant by an occupational therapist. A supervision plan and documentation for supervision is to be on file at the place of employment for each occupational therapy assistant (Chapter 138--Rules of the Occupational Therapy Section of the Board of Physical and Occupational Therapy Examiners).

Comment

Whenever service is provided by a paraprofessional such as a COTA or PTA, the service personnel should be identified in the individualized education plan. The therapist shall maintain written records of all programs.

Other Personnel

In the educational setting, other personnel (teachers, motor technicians, motor programmers, classroom aides, parents, or volunteers)

are called upon to implement activities which will enhance the pupil's motor and educational performance. These activities may be delegated by the physical or occupational therapist to maintain present skills, and practice and strengthen newly acquired skills. The types of activities which are delegated should not require the expertise of a therapist and should be appropriate for the educational environment such as walking down a hall or sitting in the classroom. The therapist should maintain written records of delegated tasks, document training of the designated personnel, and monitor the pupil's performance.

The activities which are performed by personnel other than the licensed physical therapist, occupational therapist, or occupational therapy assistant, cannot be called physical or occupational therapy.

II. SERVICE DELIVERY

INTRODUCTION

Multidisciplinary Team

Physical and occupational therapists in a school setting function as members of the multidisciplinary team identified to meet an individual pupil's needs. Members of the team may include, but are not limited to, teacher, speech and language clinician, school audiologist, school psychologist, school social worker, educational consultant, nurse, school principal, and the parents. Each team is individualized according to the needs of the pupil. For pupils requiring physical and/or occupational therapy, the respective therapist must be part of the multidisciplinary team.

The role of the physical or occupational therapist as a member of the team is to work with other members to assist the pupil and his/her family to understand the pupil's strengths and weaknesses, to plan strategies and goals for educational performance, and to anticipate outcomes for the future. Sometimes therapists, with their medical background, can be a resource to the team by explaining aspects of a medical disability and the relationship of that disability to the expected educational performance.

IDENTIFICATION

Screening

Screening is a prereferral technique which may be described as the process of surveying large numbers of general or special education pupils to identify those who warrant an evaluation. Physical and occupational therapists may be involved in screening a group of pupils or the therapist may consult and provide inservice for other school personnel who regularly screen groups of pupils.

Screening may include but, is not limited to, the use of any of the following methods:

1. Review of written information

2. Review of spoken information

3. Direct observation

Following screening, the screener should utilize AEA policies pertaining to pre-evaluation.

Pre-Evaluation Activity

Pre-evaluation activities are defined in the Rules of Special Education, 12.16(2) as an "attempt to resolve the presenting problem or behaviors of concern. These attempts may include teacher consultation with special education personnel, however, special education personnel shall neither collect new pupil specific data nor conduct an evaluation. The attempts to resolve a problem shall be documented, the parameters of a comprehensive evaluation identified, and parental permission obtained for a comprehensive evaluation if indicated."

Pre-evaluation activity has been further discussed in a paper entitled "Bureau of Special Education Pre-Evaluation Activities and Special Education Support Personnel Guidelines", August, 1986. This paper makes the assumption that pupils "should be provided assistance in regular education programs to the maximum extent feasible." Activities appropriate for pre-evaluation are outlined as including assessment, short term individual intervention as well as intervention efforts focused on the educational system.

Further interpretation of pre-evaluation activity may be made by each AEA. The role and responsibility of the OT/PT in pre-evaluation will depend on the AEA policy. Careful consideration should be made as to the amount of time the therapist can devote to pre-evaluation activities.

Referral

Referrals to the OT/PT for assessment may be made by the multidisciplinary team following a staffing, or at any time that there is a concern regarding a problem which may be interfering with the pupil's educational program. The referral process should follow AEA procedures in accordance with state and federal statutes and regulations. To assure that all pupils needing services are assessed, and to guard against over-assessment, the staffing team or referral management team should keep in mind the effect of the pupil's handicapping condition on his/her educational program, and the ability of other professionals to perform the screening and/or assessment. A referral for physical and/or occupational therapy is indicated when a problem is noted in the pupil's functional motor skills of activities of daily living, feeding, manipulation skills, positioning, and/or mobility (as listed in the following assessment section).

Assessment

Assessment refers to the process of determining the need for and nature of instruction and/or therapy support. Assessment reveals the pupil's functional strengths and weaknesses and the effect of those strengths and weaknesses on the pupil's educational performance. Motor functioning is an area which is most commonly assessed by OT/PT, however, other disciplines may be involved in this assessment, and it should not be considered the sole responsibility of OT/PT.

Assessment involves obtaining and interpreting data necessary for therapy or instruction. Data may be gathered through record reviews, specific observations, interviews, the use of standardized tests, performance checklists, and other data collection procedures.

It should be noted that "standardized tests" are not always used by occupational therapists and physical therapists. In many instances, normative data do not exist for abnormal conditions evaluated by therapists. The therapist is responsible and accountable for selecting appropriate assessment procedures that are designed to document physical status and functional abilities as they affect educational performance.

An assessment by an OT or PT should include information regarding each of the three assessment areas: 1) developmental motor level, 2) neuromuscular/musculoskeletal components, and 3) functional motor skills, as they affect the pupil's ability to meet the demands of his/her educational program. A brief description of possible subareas to consider follows each assessment area. The subareas listed under functional motor skills are those included in the OT/PT Entrance and Exit Criteria (see Appendix A).

Assessment results and recommendations must be documented according to AEA procedures. Documentation should indicate the discipline(s) which was(were) involved in the assessment.

Assessment Areas

1. Developmental motor level (objective assessment)

    a. Gross motor
    b. Fine motor
    c. Perceptual motor

2. Neuromuscular/musculoskeletal components (may include any of the following)

    a. Muscle tone
    b. Strength
    c. Endurance
    d. Joint range of motion/joint mobility
    e. Movement patterns
    f. Sensory awareness
    g. Developmental reflexes

h. Postural stability/mobility
i. Static/dynamic balance
j. Bilateral coordination
k. Visual perception
l. Hand dominance
m. Visual motor coordination
n. Motor planning
o. Dexterity

3. Functional motor skills
(Note: as stated in the introduction, these guidelines were written with the assumption that the pupil has equal access to OT/PT services. If a referral is made for both OT and PT assessment, the following division of responsibilities is intended to reflect the entry-level backgrounds of the OT and PT. Designating a primary discipline responsibility for assessment should help others within the educational system to make appropriate assessment requests. The divisions have been made to indicate the primary disciplines responsible for assessment and this is not intended to indicate treatment responsibilities (which may differ depending upon the speciality training of the therapists).

a. Activities of Daily Living--this area is primarily the responsibility of the occupational therapist.

1. Dressing - assess skills which are appropriate to the expectations of the educational program. (Example: dressing skills for a pupil in regular education may only include putting on and taking off coat, toileting, and changing shoes for P.E.)

2. Grooming/Hygiene - assess skills which are appropriate to the expectations of the educational program.

3. Domestic Living - assess skills which are appropriate to the expectations of the educational program. (Example: this area may be most appropriate for the self-contained MD and S/P classrooms.)

b. Feeding--this area is primarily the responsibility of the occupational therapist.

1. Oral-Motor - assess oral motor structure, tongue movements; swallowing, chewing, drinking skills; drooling; head-neck-trunk alignment and control; etc. Note: This assessment of oral motor skills is often the shared responsibility of the OT and PT.

2. Self-feeding - assess the motor skills required for the pupil to feed and drink with the least assistance. The pupil's postural control and positioning may be a critical part of the assessment in this area.

3. Utilizing adaptive feeding equipment - assess pupil's skills and need for training of others who assist the pupil in feeding. Assess the pupil's need for adaptive equipment.

c. Manipulation Skills--This area is primarily the responsibility of the occupational therapist.

1. Utilizing educational materials - assess the pupil's ability to use materials required in his/her educational environment. (Example: the use of pencil, scissors, crayons, glue, or computer.)

2. Meeting the speed and accuracy demands - assess the pupil's ability to perform manipulation skills in the classroom and meet the expectations of this environment. Assess the effect of motor impairment on the pupil's performance. Also assess the impact of other factors such as attention to detail, distractibility, endurance, and organization.

3. Utilizing appropriate assistive devices - assess the pupil's ability to use assistive devices and/or materials related to manipulation skills which are required for his/her individual educational program. Devices may include typewriter, computer, communication devices, etc.

4. Pre-vocational and vocational related tasks - assess the pupil's ability to manipulate materials involved in vocational activities of his/her educational program. Assess the needs for adaptive materials and/or equipment and techniques which may enhance the pupil's performance in the educational setting.

d. Positioning--this area is primarily the responsibility of the physical therapist.

1. Independent sitting, standing, etc. - assess the pupil's ability to achieve and maintain these positions independently.

2. Assisted alternative positions - assess the pupil's need for alternative positions and/or adaptive positioning equipment. (Examples: prone standers, side lyers, adapted tables and chairs.)
Note: The assessment of alternative positions is often the shared responsibility of the OT and PT.

3. Transportation - assess the pupil's need for specialized and/or adaptive positioning during transportation.

e. Mobility--This area is the primary responsibility of the physical therapist.

1. Mobility/motor skills - assess the pupil's ability to move within the school and/or home routine, including playground/recess activities. Assess all types of mobility. (Example: rolling, crawling, assisted or independent walking.)
Note: The assessment of the perceptual motor components of mobility is often the shared responsibility of the OT and PT.

2. Ability to handle architectural barriers - assess architectural barriers within the pupil's educational environment which may include: home, school, and/or the community. (Example: ramps, stairs, curbs, or rough ground.)

3. Utilizing appropriate assistive devices - assess the pupil's need for and use of assistive devices. (Examples: walkers, wheelchairs, or prosthetic and orthotic devices.)

4. Transfers - assess the pupil's ability to perform functional school related transfers. (Example: to and from desk, chair, toilet, floor, bus, cafeteria bench, or car.)

Staffing

Following a comprehensive educational evaluation by a multidisciplinary team, a staffing meeting is held by the team, including parents, to determine the need for special education services. To be eligible for special education support services, such as physical or occupational therapy, the pupil must be identified by the multidisciplinary team as having a condition which handicaps the pupil in obtaining an education. The handicapping conditions are categorized in the State of Iowa as mental disability, behavioral disordered, hearing impaired, learning disabled, communication disabled, physically disabled, and extended evaluation. Definitions of these conditions are found in the Iowa Rules of Special Education. It is the staffing team's duty to identify the handicapping condition, the pupil's educational needs as a result of that condition, and the appropriate placement in the least restrictive environment.

The staffing team documents the need for support services. The Rules of Special Education (12.18(2)f state "The special education support services specialist shall have the primary responsibility for recommending the need for support services, the extent of services to be provided, and the frequency of direct and indirect contacts with pupils requiring special education support services."

Entrance Criteria

To qualify for special education occupational and/or physical therapy support services, the pupil must meet all of the following criteria in at least one problem area: activities of daily living, feeding, manipulation, positioning, mobility (see assessment section).

Criteria:

1. The problem interferes with the pupil's ability to participate in the educational program.

2. The problem appears to be primarily sensory motor, perceptual motor, and/or motor based.

3. As documented, previous attempts to alleviate the problem have not been successful.

4. Potential for positive change in the pupil's problem through intervention or negative change without intervention appears likely. Change should be unrelated to maturity.

Therapists should document the pupil's need for the support service of physical or occupational therapy in the staffing report. A sample form for entrance and exit criteria is found in Appendix A. This form should be filled out by each discipline (OT and/or PT) evaluating the pupil and should be specific to that evaluation.

IMPLEMENTATION

IEP Development

Following the decision of the staffing team to provide a special education program and/or related services, the staffing team develops the Individualized Education Plan (IEP). As stated in the Rules of Special Education (12.18), " . . . Participants in the meeting shall include: A representative of the agency, other than the pupils' teacher, who is qualified to provide or supervise the provision of special education; the pupil's teacher; a member of the diagnostic-educational team; a teacher or other specialist with knowledge in the identified disability area; one or both of the pupil's parents subject to rule 12.31(281); the pupil, if appropriate; and, other individuals as designated by the parents, school district or director."

Decisions regarding a handicapped pupil's IEP are made jointly by all members of the team at the IEP meeting. The purpose of the IEP is to provide an individual plan of goals and objectives with anticipated strategies to meet the needs of the pupil identified by the staffing team. An IEP meeting is conducted annually to review and revise the IEP for each handicapped pupil.

According to the Rules of Special Education, 12.18(2):

"a. The IEP shall include the following:

(1) A statement of the pupil's present levels of educational performance in objective, measurable terms.

(2) A statement of annual goals describing the intended outcomes of the special education being provided.

(3) A statement of short term instructional objectives describing the intermediate steps between the pupil's present levels of performance and the established annual goals.

(4) A statement of the specific special education to be provided and the extent of the pupils' participation in the general education program.

(5) A statement describing the "specially designed" physical education program of the pupil when the pupil is not enrolled or participating in the general physical education program.

(6) A statement of the projected dates for initiation and anticipated duration of the special education for the period covered by the IEP.

(7) A statement of the criteria and methods to be applied in determining progress toward the goals and objectives of the IEP, unless specified in the statement of annual goals and instructional objectives.

(8) A statement of the projected date of graduation at least eighteen months in advance of said date and the criteria to be used in judging whether graduation shall occur. Prior to graduation, the IEP team must find that these criteria have been met. . .

f. . . .When a pupil receives special education support services in conjunction with placement in a special education instructional program, there shall be one written IEP covering all special education."

Physical and occupational therapists are included in the IEP meeting when they have been involved in the assessment of the pupil and when the staffing team identified physical and/or occupational therapy as a recommended service for the pupil. At the meeting, the therapist communicates with the parent, teacher, and other team members to explain the model of service to be provided. The team collaborates to determine the annual goals and short term objectives for the pupil. At this time, the team decides how much therapist, teacher, aide, parent, or others' time will be necessary to meet the pupil's needs. Delegation of responsibilities to team members should also be identified and documented at the meeting. The IEP should include the following in relation to therapy:

1. Primary model of service

2. Goals

3. Objectives

4. Identification of personnel for delegation of tasks

5. Frequency and duration of service

As stated in the Code of Federal Regulations (CFR 34 Ç300.346): The amount of services to be provided must be stated in the IEP, so that the level of the agency's commitment of resources will be clear to parents and other IEP team members. The amount of time to be committed to each of the various services to be provided must be:

1. Appropriate to that specific service, and

2. Stated in the IEP in a manner that is clear to all who are involved in both the development and implementation of the IEP.

A change in the model of service would constitute a change in the pupil's IEP program and would, therefore, require another IEP meeting and parental consent.

MODELS OF SERVICE

Occupational and physical therapy are support services which can be provided with greater or lesser intensity, depending upon the educational needs of the pupil. See Appendix B for considerations for service model selection. The following models of service describe the options for delivery of therapy service. A pupil may receive different models of service in different problem areas depending on the needs.

Decisions made on how these pupil's needs are met should be made by the staffing team. Consideration should be made regarding the availability and support of others to carry out intervention, the level of expertise required to provide intervention, the pupil's potential for change, and the type of equipment/environment needed.

Direct Service Model

Direct service is a model of service whereby the therapist works with a pupil individually (or in a small group) on a regularly scheduled basis to develop skills relevant to the pupil's educational performance. The therapist (or COTA under the direction of the occupational therapist) is the primary provider of service and is accountable for specific IEP short-term objectives for the pupil. The intensity of direct service is used to develop motor skills during a critical learning period for the pupil. Frequent program changes may be needed to adapt to the pupil's needs. The emphasis of direct therapy is on the acquisition of new skills which will develop the basic motor patterns needed for future motor performance. The pupil has not achieved a level of ability which would permit transfer of skills to other environments.

Intervention sessions may include the use of therapeutic techniques and/or specialized equipment which require therapist's expertise and cannot safely be used by others within the pupil's environment. In the direct service model there is not an expectation that activities will be delegated to others and carried out between therapy sessions. The actual pupil contact time including the frequency that the service will be provided should be documented in the pupil's IEP.

Integrated Service Model

Integrated therapy service is a model of service which combines direct, hands-on pupil contact with simultaneous consultation with others directly involved with the pupil. There is an emphasis placed on the need for practice of motor skills and problem solving in the pupil's daily routine. The process of goal achievement is shared between or among those

involved with the pupil. Those involved may include therapist, teacher, parents, classroom aide, and others. The IEP should reflect the pupil's educational performance rather than specific isolated motor skill development.

Intervention may include adapting activities usually occurring in the pupil's routine; creating opportunities for the pupil to practice new motor skills; dynamic positioning; and/or problem solving with others to encourage motor development and independence. Note: Only the actual pupil contact provided by the therapist or COTA under the supervision of an OT is considered therapy. Activities or follow through performed by others cannot be called OT/PT. Integrated therapy service is provided within the pupil's daily environment and should always include others involved with the pupil who can carry out the delegated activities.

Consultation Service Model

Consultation service is a model of indirect service whereby the therapist consults with the teacher, other staff, and/or parents regarding pupil specific issues. The therapist supports these individuals but is not the primary provider of service. The pupil's needs are not rapidly changing, therefore, only periodic contact by the therapist is necessary. The pupil's IEP should reflect the goals for educational performance with the therapist's input to determine appropriate expectations and possible strategies.

The therapist's involvement may include assisting teachers, other staff, and parents to understand and adapt to the pupil's disability; providing suggestions for modifications of educational materials and environment; and/or monitoring pupil's progress. Intervention procedures which are delegated to others do not require the therapist's expertise to carry them out and should not be called therapy.

THERAPY INTERVENTION

Regardless of the model of service, occupational and/or physical therapy intervention procedures should be specific to each pupil's individual needs. The techniques used should relate to the functional annual and short-term objectives identified on the IEP. There are many different intervention philosophies and strategies which the therapist may choose to use. It is the responsibility of the therapist to be aware of currently accepted therapy procedures. If a therapist is not trained in a specific area of intervention, consultative assistance should be obtained. Ongoing inservice training and continuing education goals should be identified so that therapists are qualified to meet the needs of the pupils they are serving.

EXIT CRITERIA

The pupil no longer qualifies for special education occupational or physical therapy services (see Appendix A) because he/she has completed or met one of the following:

1. Goals have been met and no additional therapy services are necessary.

2. Potential for further change appears unlikely based on previous documented intervention attempts.

3. Problem ceases to be educationally relevant.

4. Therapy is contraindicated due to change in medical or physical status.

There must be a staffing and appropriate team involvement to exit the pupil from services.

III. ADMINISTRATIVE CONSIDERATIONS

EMPLOYMENT OF OCCUPATIONAL AND PHYSICAL THERAPISTS

According to the Rules of Special Education, Department of Education, 12.3(281), "Special education support programs and services are those activities which augment, supplement, or support general or special education for pupils requiring special education and which are ordinarily provided by the AEA but may be provided by contractual agreement, subject to the approval of the board, by the school district, or another qualified agency."

The following is a list of employment alternatives:

A. Direct employment

1. AEAs directly hire OT/PT

2. Through contract with the AEA, individual school districts hire OT/PT either full-time or part-time.

B. Contract for OT/PT services

1. Contract with a public health agency.

2. Contract with a local rehabilitation facility or hospital.

3. Contract with a private practice OT/PT.

Contracted therapists should be willing to make the transition from a medical model to an educational model, as outlined previously and follow the Department of Education guidelines for practice in the schools.

AUTHORIZATION FOR SCHOOL THERAPISTS

Special education personnel shall meet all Department of Education certification/authorization for the position for which they are employed. For school occupational and physical therapists, this invovles meeting the requirement for a statement of professional recognition.

As stated in the Iowa Rules for Teacher Education and Certification, effective October 1, 1988:

73.3(12) School occupational therapist.

a. Authorization. The holder of this authorization can serve as a school occupational therapist to pupils with physical impairments from birth to twenty-one (and to a maximum allowable age in accord with Iowa Code section 281.8).

The legalization for this support personnel is through a statement of professional recognition (SPR) and not through a certificate.

b. Program requirements.

(1) Degree or equivalent baccalaureate in occupational therapy.

(2) Hold a valid license to practice occupational therapy in Iowa as granted by the division of licensure, Iowa department of public health.

Procedure for acquiring a statement of professional recognition (SPR):

The special education director (or designee) of the area education agency must submit a letter to the division requesting that the authorization be issued. Additionally, these documents must be submitted:

1. A copy of a temporary or regular license from the division of licensure, Iowa department of public health.

2. An official transcript.

A temporary SPR will then be issued for one school year. An approved human relations course must be completed before the start of the next school year. The applicant must provide evidence that:

(1) The human relations component has been fulfilled within the required time frame, and

(2) The class of license from the division of licensure is regular in the event a temporary license was issued initially.

73.3(13) School physical therapist.

a. Authorization. The holder of this authorization can serve as a school physical therapist to pupils with physical impairments from birth to twenty-one (and to a maximum allowable age in accord with Iowa Code section 281.8).

The legalization for this support personnel is through a statement of professional recognition (SPR) and not through a certificate.

b. Program requirements.

(1) Degree or equivalent baccalaureate in physical therapy.

(2) Hold a valid license to practice physical therapy in Iowa as granted by the division of licensure, Iowa department of public health.

Procedure for acquiring a statement of professional recognition (SPR):

The special education director (or designee) of the area education agency must submit a letter to the division requesting that the authorization be issued. Additionally, these documents must be submitted:

1. A copy of a temporary or regular license from the division of licensure.

2. An official transcript.

A temporary SPR will then be issued for one school year. An approved human relations course must be completed before the start of the next school year. The applicant must provide evidence that:

(1) The human relations component has been fulfilled within the required time frame, and

(2) The class of license from the division of licensure is regular in the event a temporary license was issued initially.

ORIENTATION OF NEW STAFF

In order to provide services which are appropriate and consistent with the educational system, the OT and/or PT must understand both the AEA and LEA. The following list of things should be included in the orientation of the OT and/or PT to the AEA and LEA.

A. Orient staff to the basic philosophy of OT/PT in an educational setting.

B. Provide the OT/PT with copies of:

1. State and federal laws and regulations (P.L. 94-142, 99-457)
2. Iowa Rules of Special Education
3. Department of Education guidelines for physical and occupational therapists
4. Schedule of inservice education
5. Other relevant forms, handbooks, and schedules

C. Inform the OT/PT of AEA and LEA procedures for:

1. Referral Process
2. Staffing process and development of IEP
3. Distributing reports and IEP objectives
4. Requisitioning materials and equipments
5. Other relevant procedures

D. Introduce OT/PT to:

1. Special education administrative and support staff.
2. Principals of schools serving handicapped pupils.
3. Special education teachers and aides.
4. Evaluation coordinator and multidisciplinary team members.
5. Related service personnel.

E. Provide an opportunity for the OT/PT to observe in special education classroom.

F. Orient the OT/PT to community resources relevant to handicapped pupils.

SCHEDULING AND CASELOADS

A number of factors enter into an individual therapist's schedule and caseload. Because of the variability of these factors, no definite caseload guidelines can be established.

The following are factors in determining the number of pupils which the OT/PT can adequately serve:

1. OT/PT evaluation caseload. Evaluation reports are time consuming.

2. Intensity of OT/PT service provided (predominant service model of caseloads). A greater numbers of pupils can be served with the consultative model. The more direct model of treatment provided, the smaller the caseload.

3. Location of pupils. Itinerant therapists, serving schools that are widely separated geographically, not only spend time traveling but also organizing when they arrive.

4. The amount of parent contact and parent training being done by the OT/PT.

5. Non-treatment responsibilities:

   a. Inservice to teachers and other educational personnel.
   b. Participation in continuing education.
   c. Administrative duties.
   d. Team meetings

6. Availability of secretarial assistance.

7. The experience and training of the OT/PT.

8. Presence of affiliating OT/PT student.

9. Supervision of paraprofessionals.

Note: Effective utilization of therapist time would not include requiring therapists to be responsible for cafeteria, playgrounds, or bus duties.

EQUIPMENT AND SPACE

Funds should be available to the OT/PT for specialized equipment and materials which are required to perform evaluation and treatment.

Therapists who will be providing physical/occupational therapy services should be consulted for input on the types of equipment to be ordered.

Needed equipment may include the following:

1. Positioning materials such as wedges, bolsters, prone standers, mats.

2. Therapeutic equipment such as balls, scooter boards, vestibular boards, etc.

3. Adaptive equipment such as microswitches, typewriters, tape recorders, calculators, and tools.

4. Perceptual-motor training equipment such as developmental learning materials.

5. Self-help devices such as special spoons, adaptive cups, etc.

6. Toys such as bean bags, puzzles, jump ropes.

7. Office equipment such as files, desks, etc.

Needed expendable materials could include the following:

1. Evaluative tests and protocols.

2. Adaptive equipment such as velcro, dycem, foam, strapping.

Equipment which is considered to be pupil specific and necessary to support the pupil's educational program may be procured through the LEA, the pupil's family and/or residential facility, or private donation.

Equipment which has been created and/or recommended by the physical and/or occupational therapist for use with specific pupils should include documented guidelines for how the equipment is to be used, what type of supervision is required for use, and documentation of "informed consent" which states the limitations of the equipment's use and liability.

The therapist may be held liable if an injury would result from equipment fabricated or recommended by the therapist.

The therapist may require access to woodworking or maintenance shops in order to construct and adapt equipment needed for pupil functioning within the educational environment. In addition, the therapist's access to office materials and personnel may be required to fulfill communication and record-keeping duties.

A therapist may provide many services within the individual pupil's classroom environment. However, it should be understood that the OT/PT may need additional space for individual testing and direct therapy.

DOCUMENTATION

Documentation is essential for good communication and accountability of the therapist's actions. Documentation should be specific to each discipline (OT or PT). In the evaluation process, it is important to

document the pupil's current physical status and level of motor functioning so that future changes in this condition or performance can be measured. The IEP should be used to document the models of service which the staffing team has determined most appropriate and the frequency of therapist's contact. Strategies and intervention techniques may also be included in the IEP. At the annual review of the pupil's program, the therapist should account for any changes in the pupil's performance, review the intervention plan, and document the current level of functioning. A comprehensive re-evaluation shall be conducted every three years in which the therapist should evaluate and document changes which have occurred over the past three years of intervention. Upon termination of therapy services, the therapist should again document the pupil's current level of performance, review the strategies using during intervention, make recommendations for follow-up, and identify who is responsible for follow-up.

Progress notes and attendance logs should also be included in the therapist's documentation procedures. The frequency of progress notes and program review documentation should be established by each area education agency. Therapists should be accountable for intervention time as defined in the IEP and for information regarding the pupil's progress.

SUPERVISION AND EVALUATION

Physical therapy and occupational therapy supervisors have the responsibility for the appropriate delivery of occupational and physical therapy services. They should monitor services and conduct formative/informative evaluations to determine need for changes in concepts for services being delivered, organizational structure, staffing, resources, and procedures for management of records.

OTs and PTs should systematically review their performance. This can include both self-evaluation and peer review and should focus on the quality and outcomes of their services, their relationships both within and outside of their disciplines as they affect their performance, and the appropriateness and quality of their management and administrative function.

Therapists should take an active role in reviewing, evaluating, and updating their disciplines' and agencies' policies as they relate to the practice of physical and occupational therapy in the educational system. Therapists should be aware of state and national trends which might affect delivery of therapy services to special education pupils.

During scheduled on site visitations, the Department of Education OT/PT consultants can provide assistance to the local administrators and the practicing therapists in program evaluation.

CONTINUING EDUCATION

Occupational and physical therapy licensure laws in the State of Iowa mandate appropriate continuing education. Therapists, including COTAs, are responsible for meeting these requirements. They should work with their respective agencies to identify and meet their individual continuing education needs. Inservice training should be an integral part of professional development.

The Department of Education's OT/PT consultants are available for on-site technical assistance and staff training. School OT/PT staff are encouraged to attend state-wide training sessions offered through the State Department of Education.

COORDINATION AND DELEGATED TASKS

Physical and occupational therapists are health professionals, and thus must maintain a close relationship with physicians. When a pupil's medical diagnosis has implications for educational programming, an OT or PT should obtain necessary medical information before proceeding with evaluation or intervention. Appropriately documented written and verbal communication should take place between the therapist and medical community.

The physical or occupational therapist is directly responsible for selecting which tasks related to physical therapy or occupational therapy intervention are to be delegated to other personnel. A therapist in the schools should maintain written records of tasks delegated, specific training, and monitoring of other personnel. The tasks delegated should be those of minimal risk of injury to the pupil. The specific activities that are delegated depend upon the therapist's judgment about the expertise, skill, training, and knowledge of those carrying out the activities (tasks), and the nature of the particular interventions to be delegated.

If the delegated task involves the use of specialized or adaptive equipment, recommendations for the use of this equipment should be documented as stated previously.

LIABILITY

Many physical and occupational therapists carry malpractice insurance. The method of employment (direct vs. contractual) determines the type of malpractice coverage that may be needed by the therapist.

Level and scope of authority within either employment arrangement should be understood and documented by employer and employee. Therapists are personally liable for activities outside of the designated scope of authority.

REFERENCES

Education of All Handicapped Pupils Act of 1975 (P.L. 94-142).

Education of the Handicapped Act Amendment of 1986 (P.L. 99-457).

Guidelines for Occupational Therapy in Schools, AOTA.

Iowa Physical Therapy Practice Act, Chapter 148A of 1984.

Pre-Evaluation Activities and Special Eduction Support Personnel, (1986). State of Iowa, Department of Education.

Rules of Special Education (1985). State of Iowa, Department of Education.

Rules for Teacher Education and Certification, (1986). State of Iowa, Department of Education.

The Iowa Occupational Therapy Practice Act, Chapter 148B of 1981.

APPENDIX A

OT/PT CRITERIA: FOR ENTRANCE AND EXIT

DIRECTIONS:

ENTRANCE: Following the therapist's evaluation, the student's educational problem(s) should be identified in the categories below. State educational relevance for every problem area by marking the first column with a "yes" for relevance, "no" if not relevant, or "NA" when it is not an area of concern. Then, for problem areas marked with a "yes," check those additional entrance criteria statements across the row that apply to the student. Star the final column under the Entrance Criteria heading if all criteria have been met to indicate problems to be targeted for intervention.

EXIT: Following student re-evaluation and/or program review, check any exit criteria items that apply to previously identified problem areas. Mark a zero (0) in the last column under the Exit Criteria heading when one or more of the exit criteria have been met to indicate that the problem area is no longer targeted for intervention. If exit criteria are not met, leave the final column blank. If new problem areas are identified during this process, complete a new criteria form updating the problem areas.

Student's Name: _____

Birthdate: _____

School: _____

School District: _____

Therapist: _____

Entrance Date: _____

Review Date: _____

PROBLEM AREAS	ENTRANCE CRITERIA					EXIT CRITERIA				
	Problem interferes with student's ability to participate in educational program (home for preschoolers)	Problem appears to be primarily sensory motor, perceptual motor, and/or motor based	As documented, previous attempts to alleviate problem have not been successful	Potential for change in student's problem through intervention appears likely (change is unrelated to natural recovery from acute incidence)	Target problem areas for intervention	Goals have been met and no additional goals are appropriate	Potential for further change appears unlikely	Problem ceases to be educationally relevant	Therapy is contraindicated due to change in medical or physical status	One criteria is met in problem area
I. Activities for Daily Living										
1. Dressing										
2. Grooming/Hygiene										
3. Domestic Living										
4. Other (Specify)										
II. Feeding										
1. Oral-Motor										
2. Self-Feeding										
3. Utilizing Adaptive Feeding Equip.										
4. Other (Specify)										
III. Manipulation Skills										
1. Utilizing Ed. Materials										
2. Meeting Speed & Accuracy Demands of Ed. Environment										
3. Utilizing Appropriate Assistive Devices										
4. Pre-vocational and Vocational Related Tasks										
5. Other (Specify)										
IV. Positioning										
1. Independent Sitting/Standing										
2. Assisted Alternative Positions										
3. Transportation										
4. Other (Specify)										
V. Mobility										
1. Development of Mobility/Motor Skill										
2. Ability to Handle Arch. Require.										
3. Utilizing Assistive Devices										
4. Transfers										
5. Other (Specify)										

RATIONALE: This form is to be used to determine a student's eligibility for special education occupational and/or physical therapy. It does not delineate which model of service would be most appropriate to meet the needs of the student. Keep in mind that traditional therapy concerns such as range of motion, strength, postural control, and prevention of contractures are a means for accomplishing functional educational goals and should not be the goal itself. Parts of this form will rely on professional judgment.

EDUCATIONALLY RELEVANT OT/PT SERVICES: Services which assist the teacher in evaluating student needs, program planning, and providing services to the students to optimize the child's learning and functioning within the least restrictive environment. For children not in classroom programs, educationally relevant goals are those directed toward preparing the student for acquisition of skills that will be necessary in the school setting within limitations of the student's potential.

PROBLEM AREAS

I. ACTIVITIES OF DAILY LIVING

Guideline: Provide training in dressing, grooming, and hygiene to attain appropriate levels of skills by the student and/or caregiver.

Student has a problem with one of the following:

1. Dressing
2. Grooming/Hygiene
3. Domestic Living
4. Other (specify)

II. FEEDING

Guideline: Provide student with safe and most appropriate means of receiving nutrition needed in an educational environment.

Student will have problems in at least one of the following:

1. Oral-Motor
2. Self-feeding
3. Utilizing adaptive feeding equipment
4. Other (specify)

III. MANIPULATION SKILLS

Guideline: Enhance student's ability to perform activities and manipulate instruments and materials needed in the educational environment.

Student has a problem with one of the following:

1. Utilizing educational materials
2. Meeting the speed and accuracy demands of the educational environment
3. Utilizing appropriate assistive devices
4. Pre-vocational and vocational related tasks
5. Other (specify)

IV. POSITIONING

Guideline: Assist the student or caregiver in achieving the best positioning options to maximize the student's learning in the educational environment using therapeutic principles.

Student has a problem with one of the following:

1. Independent sitting, standing, etc.
2. Assisted alternative positions (seating, standing, sidelying, etc. for feeding, toileting, etc.)
3. Transportation
4. Other (specify)

V. MOBILITY

Guideline: Assist the student in achieving the most appropriate and safe means of mobility in the educational environment.

Student has a problem in at least one of the following:

1. Development of mobility/motor skills (least restrictive alternative)
2. Ability to handle architectural requirements
3. Utilizing appropriate assistive devices
4. Transfers
5. Other (specify)

CONSIDERATIONS FOR SERVICE MODEL SELECTION

	DIRECT	INTEGRATED	CONSULTATIVE
THERAPIST'S PRIMARY CONTACT	pupil	pupil, teacher, parent, aide	teacher, parent, aide, pupil
ENVIRONMENT FOR SERVICE DELIVERY	-distraction free environment (may need to be separate from learning environment) -specialized equipment needed	-learning environment with support of others within that setting	-learning environment with support of others within that setting
METHODS OF INTERVENTION	-specific therapeutic techniques which cannot be safely delegated -emphasis on acquisition of new motor patterns	-educationally related functional activities -positioning -emphasis on practice of newly acquired motor skills in the daily routine	-educationally related activities -positioning -adaptive materials -emphasis on accommodations to learning environment
AMOUNT OF ACTUAL SERVICE TIME	-regularly scheduled sessions (such as 1/2 hour per week) -frequent program changes needed	-routinely scheduled -flexible amount of time depending on needs of staff or pupil (such as once/2 weeks)	-intermittent or as needed sessions depending on needs of staff or pupil (such as once/2 months
IMPLEMENTER OF ACTIVITIES	-occupational therapist -COTA -physical therapist	-teacher, parent, aide, school personnel -OT, COTA, PT	-teacher, parent, aide, other school personnel
IEP (short term objectives)	-specific to therapy program (as related to educational needs)	-teacher/parent - therapist combine objectives for educationally oriented IEP	-specific to educational program with therapist's input